



Haemophilus Influenzae

County _____

LHJ Use ID _____

☐ Reported to DOH

Date ____/____/____

LHJ Classification

☐ Confirmed

☐ Probable

By: ☐ Lab ☐ Clinical

☐ Epi Link: _____

☐ Outbreak-related

LHJ Cluster# _____

LHJ Cluster

Name: _____

DOH Outbreak # _____

REPORT SOURCE

LHJ notification date ____/____/____

Reporter (check all that apply)

☐ Lab ☐ Hospital ☐ HCP

☐ Public health agency ☐ Other

OK to talk to case? ☐ Yes ☐ No ☐ Don't know

Investigation
start date: ____/____/____

Reporter name _____

Reporter phone _____

Primary HCP name _____

Primary HCP phone _____

PATIENT INFORMATION

Name (last, first) _____

Address _____ ☐ Homeless

City/State/Zip _____

Phone(s)/Email _____

Alt. contact ☐ Parent/guardian ☐ Spouse ☐ Other Name: _____

Zip code (school or occupation): _____ Phone: _____

Occupation/grade _____

Employer/worksite _____ School/child care name _____

Birth date ____/____/____ Age _____

Gender ☐ F ☐ M ☐ Other ☐ Unk

Ethnicity ☐ Hispanic or Latino

☐ Not Hispanic or Latino

Race (check all that apply)

☐ Amer Ind/AK Native ☐ Asian

☐ Native HI/other PI ☐ Black/Afr Amer

☐ White ☐ Other

CLINICAL INFORMATION

Onset date: ____/____/____ ☐ Derived

Diagnosis date: ____/____/____

Illness duration: ____ days

Signs and Symptoms

Y N DK NA

☐ ☐ ☐ ☐ Fever Highest measured temp: ____ °F
Type: ☐ Oral ☐ Rectal ☐ Other: ____ ☐ Unk

☐ ☐ ☐ ☐ Conjunctivitis

☐ ☐ ☐ ☐ Eyes sensitive to light (photophobia)

☐ ☐ ☐ ☐ Other symptoms consistent with illness: _____

Vaccination

Y N DK NA

☐ ☐ ☐ ☐ Ever received Hib containing vaccine

Number of doses Hib vaccine prior to illness: _____

Dose 1 Type: _____ Date received: ____/____/____

Dose 2 Type: _____ Date received: ____/____/____

Dose 3 Type: _____ Date received: ____/____/____

Dose 4 Type: _____ Date received: ____/____/____

Clinical Finding

Y N DK NA

☐ ☐ ☐ ☐ Bacteremia

☐ ☐ ☐ ☐ Meningitis

☐ ☐ ☐ ☐ Pneumonia

X-ray result: ☐ P ☐ N ☐ I ☐ O ☐ NT

☐ ☐ ☐ ☐ Epiglottitis

☐ ☐ ☐ ☐ Otitis media (otitis media alone does not meet the case definition for H. influenzae)

☐ ☐ ☐ ☐ Cellulitis

☐ ☐ ☐ ☐ Pericarditis or pericardial effusion

☐ ☐ ☐ ☐ Osteomyelitis

☐ ☐ ☐ ☐ Septic arthritis

☐ ☐ ☐ ☐ Coma

☐ ☐ ☐ ☐ Admitted to intensive care unit

☐ ☐ ☐ ☐ Mechanical ventilation or intubation required during hospitalization

P = Positive
N = Negative
I = Indeterminate
O = Other
NT = Not Tested

Y N DK NA

☐ ☐ ☐ ☐ Vaccine up to date for Hib

Vaccine series not up to date reason:

☐ Religious exemption

☐ Medical contraindication

☐ Philosophical exemption

☐ Previous infection confirmed by laboratory

☐ Previous infection confirmed by physician

☐ Parental refusal

☐ Other: _____

☐ Unk

Hospitalization

Y N DK NA

☐ ☐ ☐ ☐ Hospitalized for this illness

Hospital name _____

Admit date ____/____/____ Discharge date ____/____/____

Y N DK NA

☐ ☐ ☐ ☐ Died from illness Death date ____/____/____

☐ ☐ ☐ ☐ Autopsy Place of death _____

Laboratory

P = Positive O = Other
N = Negative NT = Not Tested
I = Indeterminate

Collection date ____/____/____

Source _____

P N I O NT

☐ ☐ ☐ ☐ ☐ H. influenzae type b antigen (CSF) [Probable]

☐ ☐ ☐ ☐ ☐ H. influenzae culture from a normally sterile site Site

Serotype: _____

☐ ☐ ☐ ☐ ☐ Beta lactamase resistance testing of isolate

INFECTION TIMELINE

Enter onset date (first sx) in heavy box. Count forward and backward to figure probable exposure and contagious periods

Days from onset:

Exposure period

-7 -1

o
n
s
e
t

Contagious period*

As long as organisms are present (may be prolonged)

Calendar dates:

* If treated, 24-48 hours after onset of effective antibiotic therapy

EXPOSURE (Refer to dates above)

Y N DK NA

☐ ☐ ☐ ☐ Travel out of the state, out of the country, or outside of usual routine
Out of: ☐ County ☐ State ☐ Country
Destinations/Dates: _____

Y N DK NA

☐ ☐ ☐ ☐ Contact with lab confirmed case
☐ Household ☐ Casual ☐ Sexual
☐ Needle use ☐ Other: _____

Y N DK NA

☐ ☐ ☐ ☐ Does the case know anyone else with similar symptoms or illness

Where did exposure probably occur? ☐ In WA (County: _____) ☐ US but not WA ☐ Not in US ☐ Unk

Exposure details: _____

☐ No risk factors or exposures could be identified

☐ Patient could not be interviewed

PATIENT PROPHYLAXIS / TREATMENT

Y N DK NA

☐ ☐ ☐ ☐ Treated for nasopharyngeal carriage

PUBLIC HEALTH ISSUES

Y N DK NA

☐ ☐ ☐ ☐ Attends child care or preschool
☐ ☐ ☐ ☐ Do any household members or close contacts work at or attend childcare or preschool

PUBLIC HEALTH ACTIONS

☐ Prophylaxis of appropriate contacts recommended
recommended prophylaxis: _____
receiving prophylaxis: _____
completing prophylaxis: _____

NOTES

Investigator _____ Phone/email: _____ Investigation complete date ____/____/____

Local health jurisdiction _____ Record complete date ____/____/____